Management of Pathology MBS Outlays Options Paper

Introduction

The Australian pathology sector comprises three large private pathology providers, a number of medium sized operators, a small number of specialty operators and 19 public pathology providers.[1]

Public pathology services receive funding principally from State Government via Local Hospital Districts, from the Medicare Benefits Schedule (MBS)[2] for privately referred non-inpatients, and from third party organisations for other compensable patients (such as DVA, WorkCover, private insurers). These organisations use the MBS as the basis for their funding models. Furthermore, as part of the funding arrangements within Local Hospital Districts, a number of public pathology services operate on a fee for service basis, where fees are referenced to the MBS. Thus, the MBS has broad reaching effects on the public pathology sector.

Total funding for MBS outlays is outlined in the Pathology Funding Agreement for 2011/12 – 2015/16 (the Agreement).[3] The Agreement specifically refers to exploring a standard mechanism for setting fees under the Pathology Services Table of the MBS.[4] With increasing levels of pathology activity, and MBS expenditure subject to a cap by the Agreement, there is a pressing need to examine options for managing MBS outlays. Options should fit within the principles of the Agreement, ensure patients have continued access to quality, affordable pathology services and foster the long term fiscal sustainability of the pathology sector.

The purpose of this paper is to explore options for managing within the expenditure cap of the Agreement and recommend a preferred position.

Scope

The Agreement is intended to promote value for money from Government MBS outlays, through setting maximum (and minimum) outlays for each year of the Agreement and instigating processes for ensuring that outlays are within the agreed range below. [5]

	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Outlay target cap	$2165.8 m	$2271.9m	$2384.4m	$2502.4m	$2632.5m
Growth rate cap	4.875%	4.900%	4.950%	4.950%	5.200%

At the end of the second year (June 2013), expenditure was over the cap and growth was tracking above the 4.9% allowance.

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1 NSW Health Pathology comprises four independent operating units (excluding its Forensic Division) and as such is treated as four services.

2 Reference to the MBS pertains only to items in the Pathology Services Table (PST) for the purposes of this paper. MBS, PST, Table and Schedule are used interchangeably in this paper.

3 The Agreement can be found at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PFA.

4 Clause 24 of the Agreement.

5 Unadjusted targets are displayed.

The current challenge of managing within the cap is detrimentally impacted by an underestimate of the base year activity.[6] However, this and other pressures such as lack of parity between public and private providers for Patient Episode initiation (PEI) items and the impact of coning are beyond the scope of this paper.

MBS fees do not reflect the true cost of a pathology test. Ernst & Young consultants have been engaged by the Federal Government Department of Health (the Department) to develop a transparent MBS fee setting mechanism for new items. As such, this aspect and the treatment of new items, is also beyond the scope of this paper.

The current system does not encourage best requesting practice. There is no emphasis on maintaining the currency of the MBS in line with best clinical practice. The current system rewards providers with high volumes, rather than focussing on high value tests and ordering practices that contribute to better patient outcomes. The subject of this paper is to describe mechanisms that could be deployed to manage demand and realign the MBS with the principles of the Agreement when expenditure on pathology exceed the cap.

Guiding Principles

NCOPP's vision is for public pathology to be recognised as an integral clinical service that enables quality health outcomes. As such, NCOPP's approach to managing MBS demand reflects the importance of using evidence based practice for the benefit of patients.

Key objectives under the Agreement should be applied when evaluating options to manage demand. These are to:

- Maintain the quality, access and affordability of pathology services;
- Improve the fiscal sustainability of Government outlays on pathology;
- Maximise competition in the pathology sector;
- Improve the integration of pathology with the e-Health agenda;
- Support improved quality of requesting of pathology services;
- Provide stability of the regulatory and funding environment in order to encourage investment in continuing improvements in the quality of the service; and
- Recognise the diversity of private, public not-for-profit pathology, small and large, metropolitan and regional providers, ensuring the sustainability of the pathology sector.

[6] The target outlay for the first year of the agreement was based on outlays forecast by the Commonwealth Government for 2010/11. This was $21.7 million below the actual outlay for the 12 months to 30 June 2011. The impact of this is estimated to be $125.8 million over the term of the Agreement.

The Options

A percentage fee reduction across the entire MBS Pathology Services Table (PST) was once thought to be the most expeditious way of implementing a fee reduction (to avoid a larger cut at a later stage). However, a fee cut across the whole PST is a significant administrative burden for Australian Government Departments. It is noted that the most recent fee reduction effective from 1 January 2013 was a *hybrid* 0.69% across the board cut and a $3.50 reduction to Vitamin D related Items 66608 and 66609.[7]

Items are rarely removed from the PST of the MBS.[8] However, this is not the case in other sectors. The Pharmaceutical Benefits Advisory Committee (PBAC) may recommend removal of a drug from government subsidy under the Pharmaceutical Benefits Scheme (PBS) if:

- A more effective or equally effective but less toxic drug becomes available;
- Evidence becomes available that the effectiveness of the drug is unsatisfactory;
- Evidence becomes available that the toxicity or abuse potential of the drug outweighs its therapeutic value;
- The drug has fallen into disuse or is no longer available; or
- Treatment with a drug is no longer deemed cost-effective compared with other therapies.[9]

PBAC follows due process in considering the removal of a drug, including consulting with affected stakeholders. While the PBS administratively and structurally different to the MBS, there is no reason why a similar process could not be adopted in managing pathology items.

The options that are explored in this paper are:

1. Hybrid approaches
2. Removal of MBS PST Items
3. Targeted MBS Item fee reductions
4. Volume based discounting
5. Co-payments
6. Across the board fee reduction
7. Coning for specialist referrals
8. Communication of cost information.

1. Hybrid approaches

A hybrid model is a combination of any of the models mentioned above. The main benefit of a hybrid model is that it offers flexibility to tailor an approach which may be more likely to resonate with stakeholders while aligning with the principles of the Agreement. It may be difficult to reach consensus on the elements of the hybrid options. An agreed decision tree may assist in overcoming any difficulties. The hybrid approach shall be discussed in greater detail following review of other models.

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7 mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/News-201301-January-MBS

8 There will be some examples of item removal from the PST, but very few (e.g. Euglobulin clot lysis time 65140).

9 http://www.pbs.gov.au/info/industry/listing/elements/pbac-guidelines/a-part-1/section-1

2. Item removal

The government can make MBS fee changes without undergoing formal review or consultation procedures within the terms of the Agreement. However, a sector-led process for selecting items to be removed is aligned with the principles of the Agreement with regard to demand management, would create room within the cap to allow investment through Government subsidy in emerging diagnostic tests maintaining the currency of the Schedule, and would create competition. It would also facilitate reimbursement for tests that are usually coned out. Charging sends a price signal to clinicians and patients about the value and cost of pathology. However, it carries political risk and is contrary to the intention of the government's bulk billing policy.[10] A safety net for relatively disadvantaged patients would also be required.

The PST has been actively managed by a Committee since the late 1980's. During this time, many services on the Table have been included, modified and re-arranged, but, removal of items has been extremely infrequent. This means there is a considerable opportunity to critically review the Table and remove obsolete items and review the descriptors of others to make them contemporary with current laboratory and clinical practice.

The Medical Services Advisory Committee (MSAC) applies an evidenced based approach to ensure that new and existing medical procedures attracting funding under the MBS are supported by evidence of their safety, clinical effectiveness and cost-effectiveness. MSAC has a review mechanism for current items. This can be for an individual item or for a large group of items. Individual items must go through the full MSAC review process which is cumbersome (e.g. review of HbA1c to modify the descriptor so it can be used for diagnosis of diabetes). Groups of items are generally reviewed as part of a process which includes representatives of the relevant clinical group and Department staff (e.g. review of all ophthalmology items). When completed, the final changes are sent to MSAC for formal consideration and recommendation.

A process could be developed to remove items from the PST. Recently, the Royal College of Pathologists of Australasia (RCPA) undertook a process through its Discipline Advisory Committees to define tests that could be removed or altered in order to meet the 2012/13 overspend.

The following could be applied to guide the process of selecting items for removal:

1) Test has fallen into disuse or is no longer available;
2) A more effective or equally effective test is available under the MBS;
3) Evidence becomes available that the effectiveness of the test is unsatisfactory;
4) A more effective or equally effective test is available at cheaper cost;
5) Low cost item that is usually coned out.

[10] http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2009-hmedia14.htm
The bulk billing incentive is between $1.60 and $4.00 an episode, depending on the type of test and where it is collected. This measure provides an incentive for providers to maintain or increase bulk billing rates, providing tests at no cost to patients.

3. **Targeted item fee reduction**

Under a targeted model, specific items are selected for a fee adjustment. One of the main benefits of this approach is that items can be targeted for a fee reduction in line with contemporary laboratory and clinical practice. Targeted changes are much easier for Government Departments to implement because the change is to an individual item or limited group of items rather than the whole MBS. However, targeted fee adjustments take longer to decide upon and the anticipated change to total outlays may be affected by the coning rules.

In order of preference, selection could be based on the:

1) Clinical utility of the test (items with no or little clinical efficacy would be selected);
2) Inappropriate/redundant use (e.g. frequency more than a certain number / repeat requests within a certain time frame);
3) Analytical performance of the test;
4) Volume of tests performed (targeting high growth items would have maximum monetary impact and minimise the quantum of fee adjustment);
5) Relationship between the current fee and the cost of performing the test (i.e. items would be selected where the MBS fee far exceeds the true cost of the test); and
6) Relationship to other similar items on the MBS.

4. Volume based discounting

The volume based discounting option is based on the principles of purchasing power to discount high volume pathology services that benefit from economies of scale. A discount would take effect once a particular volume of tests are reached.

Large pathology organisations can secure cheaper rates for purchasing equipment and consumables in bulk and maximise efficiencies in courier networks. For highly automated tests, the marginal cost of each individual test decreases as the volume increases, with laboratories processing the highest number of tests having the greatest economies of scale.

Volume based discounting may offer flexibility in that a discount may be offered on a sliding scale, in general terms or through a more targeted approach.

Volume based discounting involves the following elements:

1) Identifying the items to which a discount will apply;
2) Identifying high-volume providers of those items;
3) Identifying the volume at which the scale efficiency should be realised; and then
4) Identifying the quantum of scale efficiency discount to be applied.[11]

Volume based discounting best suits highly automated, high volume tests that generate efficiencies of scale (e.g. haematology and chemical pathology, P1 and P2 items). The point of application for the discount should be based on throughput rather than expenditure. Throughput may be determined at APL laboratory level (rather than corporate (APA) level) as scale efficiencies are maximised at an individual laboratory level. Alternative approaches use the corporate APA level and beneficial ownership.

[11] Australian Government Department of Health & Ageing, Review of the Funding Arrangements for Pathology Services, 2011, p.49-50.

An ascending scale of discount with a higher discount for greater volumes is preferred to a flat rate as this captures the decreasing marginal cost per test with increasing volume. E.g. services which are 5% - 10% above the threshold could be discounted by 20%; services which are 10-20% could be discounted by 35% etc. However, some larger providers have indicated that the relationship between cost per test and volume varies between tests and is not always linear, so modelling the impact of any proposed changes on the industry may be difficult.

Eligibility threshold could be defined as providers with more than a fixed percentage of the total national volume. Reallocation of testing to minimise the impact of volume based discounting must be mitigated by regulations with monitoring and enforcement.

5. Co-payments

Under the co-payment option, pathology providers can charge patients a fee for pathology tests. The co-payment would supplement the amount the provider receives under the MBS. Co-payments may cause patients to question their referring clinician about the real need for pathology tests. This could tighten requesting practices. Co-payments may also deter patients from having pathology tests - which would reduce the financial impact of pathology services but may lead to higher consequential costs associated with delays in receiving health care. This could partially be mitigated by a safety net for low income earners.

Pathology has high rates of bulk billing. This rate has been fostered by the bulk billing incentive and pressures of competition. If a co-payment was mandatory for all tests, this may preclude access to pathology and carry significant political risk. Patients are used to having their pathology tests bulk billed and could form an adverse opinion about the government if this changed. A co-payment for tests that have low clinical utility may be more acceptable.

This model may be difficult to implement. The pressures of competition may preclude charging co-payments unless these were mandatory. Some jurisdictions are also constrained by their governments' policies of not charging patients for medical services in a public hospital district facility. This practice has led to an expectation that only the schedule fee will apply to pathology services provided by public sector laboratories. Collection of a co-payment would add an administrative burden to services the costs of which may not be recouped if the co-payment is not sufficiently high. All of these factors indicate that this approach would be difficult to implement in the public sector.

6. Across the board fee adjustments

'Across the board' changes have been made regularly in the past and involve an agreed percentage adjustment to all items in the Table. It is also possible to exempt some items or groups of items from an across the board change (e.g. exempt items recently added to the Table or all items in Group P6).

The advantage of such a change is that it is easier to predict the changes to outlays; it is easy to model the impacts on the industry. The main disadvantage is that it maintains the current imperfections of the Schedule. This option does not advance the principles of the Agreement and does not encourage best requesting practice.

7. Introduction of coning for specialist referrals

The coning rule applies to out of hospital pathology services requested by general practitioners and limits the benefits payable to only three pathology services with the highest schedule fee within a single patient episode. The coning rule applies to all items on the PST unless specified.[12]

Coning is not currently applicable to tests requested by Specialists. The number of specialist referred tests are significantly lower than tests requested upon a non-referred basis.[13] Thus if coning was introduced to specialist requests, this may not have significant impact on MBS expenditure.

Furthermore, coning is an artificial means of controlling demand, where pathology providers are unfairly penalised. Coning also skews activity data sets – leading to difficulties in assessing the impact of demand management and policy decisions.

8**. Communication of cost information**

There is some evidence that communication of information on price/cost per test reduces request numbers. Information on the price of pathology tests may be able to be included in a price panel of commonly requested tests on a request form or in GP desktop ordering software. However, there is no evidence to suggest that this is a sustainable solution to manage demand. If there were to be any impact, it may be short lived. More significantly, as requesters are not financially impacted by the fee, this would do little to change requesting behaviour.

Recommended position

A model that combines removal of obsolete or redundant items from the schedule and targeted fee reductions is the preferred approach to managing MBS activity within the cap, as this provides flexibility whilst fitting within the principles of the Agreement. The model should firstly consider item removal as this would assist in maintaining the currency of the MBS. Targeted fee reduction should then be progressed. Steps could be repeated following the guidelines below until the financial target is reached.

Whilst mandatory co-payment for pathology services has some advantages from a demand management perspective, implementation in the public pathology sector would be problematic and may be more easy to implement if narrowly targeted at consultations in primary care (as suggested in submissions made to the Federal Government's Commission of Audit).[14]

Across the board fee reductions and coning for specialist referrals should not be considered for the reasons mentioned above.

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12 Clause 15.5 MBS

13 MBS attendances for 2012/13 were: specialists 26,607,381 compared to non-referred attendances of 128,862,555 (Department of Health, 2013).
Australian Centre for Health Research submission to Federal Government Commission of Audit 2013:
http://www.cormorant.net.au/images/18%20oct%202013%20achr%20gp%20copayment%20paper%20final.pdf

Recommended approach

Step 1 Signatories to the Agreement propose item(s) for removal on the basis that:

1) The test has fallen into disuse or is no longer available;
2) The test is of low clinical efficacy;
3) A more effective or equally effective test is available at cheaper cost;
4) The test is a low cost affordable test that is usually coned out.

Step 2 The impact of removing the item(s) is modelled.
Signatories agree on the item(s) to be removed.
The outstanding financial target is to be achieved by item fee reduction.
(In the unlikely event of no items being agreed upon for removal, targeted fee reduction is pursued only)

STEP 3
Item(s) selected for fee reduction on the basis that:

1) The test has low clinical efficacy;
2) There is inappropriate/redundant use (e.g. frequency more than a certain number / repeat requests within a certain time frame contrary to acceptable clinical guidelines)
3) Analytical performance of the test is poor or variable;
4) The MBS fee far exceeds the true cost of the test; and/or
5) There is a high volume of tests performed.